TBI IMAGING ASSOCIATES

www.tbiia.com
Phone #: 866-987-1998
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REFERRAL/INTAKE FORM FOR DTI (can also be completed on our website)

PATIENT INFORMATION (information in RED is required)

Date

Patient Name

Patient Phone #

Gender
M ☐ F ☐

Patient City, State, and Zip Code

Date of Birth

Commercial Policy
Yes ☐ No ☐

Referrer Name & Phone #

Referrer Email Address

Practice Name & Phone #

Contact Person Name & Phone #

Contact Person Email

SERVICES REQUESTED

- ☐ Diffusion Tensor Imaging (DTI)
- ☐ Expert Witness Work/Depositions/ Trial Services for DTI

If available, please also send:
1. Clinical Notes
2. Imaging Results

REASON FOR REFERRAL

Traumatic Brain Injury (TBI) / Concussion

Symptoms/Indications (select all that apply)

- ☐ Positive CT scan after trauma
- ☐ Loss of consciousness
- ☐ Memory loss and/or concentration problems
- ☐ Depression and/or anxiety
- ☐ Personality changes, bursts of anger, or other mood swings
- ☐ Difficulty in planning or other abnormalities with thought processes
- ☐ Speech abnormalities
- ☐ Difficulty in going to sleep, staying asleep, or excessive sleep/sleepiness
- ☐ Other (please specify)

Date of Injury

MECHANISM OF INJURY

- ☐ MVC
- ☐ 18-Wheeler Accident
- ☐ Fall
- ☐ Industrial Accident
- ☐ Blast
- ☐ Electrocution
- ☐ Toxic Gas
- ☐ Others (Specify)

PATIENT PREFERRED LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Other

Miscellaneous Notes

• Headquartered in Houston, TX •

Fax to 1-866-833-4910 or email to referrals@tbiia.com